Critical Interaction Therapy: Couples Therapy in Combat-Related Posttraumatic Stress Disorder

DAVID READ JOHNSON, Ph.D.†
SUSAN FELDMAN, M.S.W.‡
HADAR LUBIN, M.D.§

There is a need for family therapy interventions that are specific to the conditions found in families of traumatized people such as combat veterans. In these families, the historically "real" event of the trauma often continues to exert influence on the family system despite collusive arrangements that serve to keep it hidden. In families of combat veterans, a situation develops whereby the veteran becomes triangulated with a dead buddy without the spouse's knowledge. The discrepancy between past and present emerges in what we call the critical interaction *between the spouses. This article outlines a method of couples therapy that attempts to demystify this critical interaction, and begins to integrate the discrepant narratives of each spouse. The establishment of a nascent mutuality of perspective within the couple releases energies that can be directed toward support rather than symptom-formation in the family system.*

Fam Proc 34:401–412, 1995

† Associate Professor of Psychiatry, Yale University School of Medicine. Send correspondence to National Center for PTSD, VA Medical Center, 950 Campbell Avenue, West Haven CT 06516.

‡ Director, Common Ground, Grant Street Clinic, Hill Health Center, New Haven CT.

§ Assistant Professor of Psychiatry, Yale University School of Medicine; Chief, Inpatient Unit, National Center for PTSD, VA Medical Center, West Haven CT.

THE treatment of the family and the marital couple in posttraumatic stress disorder (PTSD) is receiving greater attention, particularly as the effects of secondary traumatization on family members are being discovered (Figley, 1989; Harkness, 1993; Herndon & Law, 1986; Jurich, 1983; Marrs, 1985; Rosenheck & Thomson, 1986). Nevertheless, models of family therapy specifically designed for PTSD patients have been only briefly described (Williams & Williams, 1985) despite the presence of unique elements within PTSD families (for example, the existence of a historically "real" trauma). In this article, we will offer one such model of couples therapy work with male Vietnam veterans and their wives, though the principles we describe may also be applicable to other forms of trauma.

The potential importance of family therapy and couples therapy with Vietnam veterans suffering from PTSD is suggested by much evidence of domestic violence, divorce, substance abuse, and behavioral problems within these families (Figley & Sprenkle, 1978; Matsakis, 1988; Silver & Iacono, 1986; Stanton & Figley, 1978). Reduction of family dysfunction not only can aid the veteran in his own recovery, but also limit the negative impact of the disorder on the spouse and children (Figley, 1986). Figley (1989) has provided a useful overview of family work with trau-

0014-7370/95/3404-0401/$02.00/0

matized families, which involves a five-phase approach that reflects the unique needs of victims of trauma. These phases—building commitment, framing the problem, reframing the problem, developing a healing theory, and closure—integrate useful aspects of structural, strategic, systemic, and narrative family therapy methods. We agree with his overall goals of family treatment: to help family members make peace with the past, to provide education about trauma and its sequelae, to increase their capacity for supporting each other, and to improve their relationship skills (Figley, 1989, pp. 31–42). Appreciating the family's pre-trauma resources and perceptions, the specific nature of the traumatic event, and the family's post-trauma adaptation (including coping skills, perceptions, and resources) serves as a fundamental framework from which to build an appropriate treatment strategy for each particular family (McCubbin & Patterson, 1983). Nevertheless, certain general patterns of behavior and relationship are often seen in families of Vietnam veterans with PTSD, which we will now briefly review.

The General Context

Families of Vietnam veterans with PTSD often are beset by numerous difficulties and stresses, with many similarities to and some differences from other kinds of dysfunctional families (Figley, 1983). Violence, flashbacks and dissociative events, social isolation, rigid rules, gun collections and bunkers in the basement, chaotic employment patterns, and an overall negative, denigrating environment are not uncommon. Many couples have been largely ignorant of the potential effects of PTSD and have instead attributed their marital problems to substance abuse, bad match, or each other's personality characteristics. They have become isolated from friends, family, and neighbors. Their children rarely bring friends home. All social needs are met within the closed system of the family, whose members feel inferior and defensive in respect to other families. The veteran has great difficulty carrying out his roles of husband, father, and son. With his wife, the veteran alternates between defensive and offensive positions, either criticizing her or withdrawing from her, caught in a repeating cycle of shame and blame. With his children, he is disturbed by memories of children in Vietnam. He is fearful of hurting them and impatient with them for being children. He feels it is dangerous to be a vulnerable, innocent, and trusting child, and prefers that they grow up fast. He has little tolerance for play, crying, or fighting, and expects perfection.

As a result of these difficulties, his wife often becomes over-functioning. She works, cooks, manages the finances, and is the emotional caretaker for husband and children. She is the liaison to the outside world of school and extended family. She has become triangulated between her own family, husband's family, and her husband. She makes excuses for his behavior, defends him against their criticisms, and receives the brunt of his anger when she insists on going to family functions. She feels trapped, misunderstood, and neglected. She feels stupid for staying in the marriage, yet guilty for having failed in her mission should she choose to leave (Matsakis, 1988).

The veteran cannot tolerate the emotions or feelings expressed by his family, and often reacts with anger, harshness, or withdrawal. The other family members learn that it is dangerous to express emotion with the veteran and, instead, turn to each other for comfort, thus excluding the veteran from the love in the family and leaving him feeling abandoned. They build a consensually validated theory of the problem based on his personality faults, which is not shared with the veteran for fear of reprisals. This leads to the development of

secondary traumatization among members of the family who begin to show signs of numbing, hypervigilance, anger outbursts, depression, and anxiety, which may lead to substance abuse or even suicidal behavior (Figley, 1983). The veteran, in turn, perceives these behaviors in light of his sense of abandonment and rejection by society when he returned from Vietnam, thereby invalidating or minimizing their suffering.

Cut off from his family, avoided and feared, unable to fulfill his expected roles, the veteran turns to the memories of his dead buddies and combat experiences for solace, understanding, and justification. These form the nucleus of an account of self and world that is centered on and defined in terms of his past traumatic experiences. Few in the present can measure up to the idealized and emotionally charged bond that the veteran has developed with the unmourned dead. Treasuring and not sharing his personal narrative, he becomes a stranger in his own home, while Vietnam remains his home. The skills learned in war are of little use now. He is confronted daily with men his own age who seem to be negotiating midlife passages with apparent ease. He thinks, "My family would be better off without me, and I would be better off joining my dead buddies." Though the past validates the veteran, it stands in the way of adaptation to the present. From the perspective of the life cycle, the veteran is now confronted in midlife with a crisis of allegiance to his family and society.

Challenges for Couples Therapy

There is general recognition that it is important for the veteran to share his combat-related, traumatic memories with his spouse so that the disjunction between them can be bridged (Figley, 1989). Rosenheck and Thomson (1986), however, note that this can be difficult for the couple: the veteran can become overwhelmed, and the spouse may react too quickly with patronizing platitudes that show an inadequate understanding. They recommend initial disjoint meetings to allow for ventilation, education, and preparation of family members. "Before disjoint treatment, issues involving loss, fear, or anger, which so frequently emerge in family discussions, trigger a subtle but potent, nonverbal reaction in the veteran that brings the discussion to a dead halt" (p. 568). We also have noticed this nonverbal reaction, which, as we will demonstrate below, can be used as an opening into a therapeutic encounter between the couple. Nevertheless, we have often found that we are confronted with a couple that requires more immediate intervention than would be possible if there is a longer sequence of disjoint and then conjoint meetings. Delaying the communication about the trauma can sometimes build up anticipatory anxiety in the veteran, who may drop out of treatment before the "big" session. We are interested in designing a method of couples treatment that can provide sufficient support for both parties to allow the traumatic story to be told and the grieving to begin. Eventually a mutually held perspective on the problem can be established and can provide the ground for future therapeutic work.

Another major challenge to couples therapy is that of establishing a balance between the needs of the veteran and the spouse. Typically, the spouse assumes that the therapy is largely directed toward the veteran's needs (especially when the treatment is conducted within a VA Medical Center). When the traumatic material is explored, she feels she needs to take a back seat, and that she is expected to provide support even if the veteran has often been abusive and irresponsible. He becomes the victim who deserves sympathy. This often leads her to drop out of couples meetings. The therapeutic challenge is to demonstrate within the initial couples session

that the veteran's increased openness to his traumatic material will lead to or be associated with a greater capacity to care for his family and, specifically, his wife.

THE CRITICAL INTERACTION

Rosenheck and Thomson (1986) point out an important tension within the family therapy literature on traumatized families: between the "constructivist" traditions of the family therapy movement, which emphasizes the absence of objective reality, and the "realism" of the trauma-victim literature, which emphasizes the need to encounter the "historical truth" of the traumatic event. We propose that families of traumatized people are also challenged by this tension between the historical reality of the trauma and their need to establish and create a coherent family reality. How is a family to redefine itself after a member has been raped? The desire to get on with life and to put the trauma behind them deposits the suffering inside the victim and supports a culture of denial within the family. Yet, open acknowledgment burdens the entire family with shame: Why should the children be subject to growing up in a "victim-of-rape-family," or an "incest-family"? We believe that one means by which the family attempts to solve this dilemma is through the spontaneous development of what we call the *critical interaction.*

The critical interaction is a repetitive conflict between the couple that is covertly associated with a traumatic memory of the veteran. The memory nearly always contains people with whom the veteran has a strong emotional bond. The conflict with the spouse evokes the traumatic memory in the veteran without any overt recognition of parallels between the two worlds. The resulting overlap of relationships prevents the original conflict from being resolved. The veteran and spouse are triangulated with a shadow. The critical interaction is an attempt by the couple, however dysfunctional, to bring together and integrate the family reality with a disturbing historical event. Over time, typical conflict patterns within the couple become shaped by the traumatic material of the veteran, as the family system unknowingly assimilates the veteran's war experience. We believe this process may be the mechanism of secondary traumatization in which trauma is passed on to the next generation (Kishur & Figley, 1987).

The critical interaction, like many symptoms, is therefore a compromise formation, a story encapsulating a double-entendre. It is an attempt both to symbolize the traumatic experience within the couple's interaction and to avoid awareness of the trauma. Stressful experiences in the present activate memories of traumatic events in Vietnam that parallel the emotional tone of the present conflict. It is the past that is then responded to in the present, much like the unconscious flashbacks described by Blank (1985). The rigid pattern of interaction maintained between the couple does not allow for a working through or mourning of the past. Therefore, the present remains conflictual while the past maintains an undemanding quality that is more soothing than traumatic. The demands of the spouse upset the veteran, while the past appears to embrace and tolerate the veteran. As a result, the memory remains unmourned and unacknowledged; each member of the couple feels misunderstood, shamed, and enraged; and communication ends since neither person can listen without reacting defensively.

We have found in our clinical practice that a specific critical interaction generally follows this sequence:

1. Conflict with spouse.
2. Evocation of distressing emotion (shame, anger).
3. Veteran's attention turns to the parallel event in Vietnam.

4. Withdrawal from the spouse or explosive rage reaction.
5. Communication ends.
6. Fear, anger, and hopelessness prevent problem solving.
7. Each spouse's personal narrative of the problem is consolidated further.
8. Conflict is repeated.

The following three examples demonstrate the striking parallels between present conflicts and past traumatic events that are revealed within the critical interaction.

Example 1: Revenge

Bernie and Christine were talking about how they each lived in separate quarters in the house, and after an argument, how Bernie often sought "revenge" by breaking something of hers. As they talked, they got into an argument about one of their children who had not come to a picnic the day before. She claimed their son was not even his. His eyes glazed over. When asked about this, he told the following story. A villager was caught stealing some weaponry the day after several of his buddies had been killed by snipers near the village they were protecting. Assuming this villager was guilty, Bernie shot him in the head, tied his body to a rope and dragged it behind a tractor into the village square. He then backed up over the body, back and forth, until "it was hamburger," to show the villagers what would happen. "I got my revenge," he told his wife. His job at the picnic? Cooking the hamburgers.

Example 2: Sweet Lips

Paul and Janet were talking and arguing about an upcoming vacation. When Janet said angrily that she just would not go, Paul became upset and said, "You won't go with me?" Janet did not respond. "Talk to me, Sweet Lips." Sweet Lips was her nickname. Paul then stared at the floor and began to shed tears. The therapist asked if Paul was remembering something from Vietnam. Yes. Janet is asked to hold his hands while he tells her the story. He was on a mission with his M-60 machine gun when they were hit. He was covering his squad and he prayed that his weapon would not jam, so he talked to it and said, "Speak to me, baby, speak to me." It did not jam, and no one was hurt. From then on he named his weapon "Sweet Lips," and, unconsciously, had begun calling Janet that name years later. Whenever she would "jam up" in their interaction, he was reminded of the incident.

Example 3: Asleep on Watch

John and Mary were talking in therapy about his habit of lying on the sofa all day watching TV, even when their four children came home from school. The house had five TV sets. As Mary was scolding him in a humiliating way about never getting off the sofa, John looked down. Again, a memory emerged. Mary was asked to hold him as he cried and told this story. While on patrol, he fell asleep and awoke as his sergeant was kicking him and yelling, "Get up, get up!" Apparently a line of Viet Cong had just come down the path. He jumped up in a panic and began firing immediately, only to have the officer start yelling at him to stop. He had killed four village children who had wandered from the village.

CRITICAL INTERACTION THERAPY MODEL

The purpose of the critical interaction approach is to teach the couple about their interactional process and decrease the blaming; to bring to light the underlying traumatic memories of the veteran and allow the spouse to engage in the role of witness to the veteran's mourning; to help the veteran differentiate the past from the present and engage in the role of caretaker for the spouse; and then to help the couple problem solve and practice better communication. The treatment of the triangu-

lated relationship involves opening the barricade between the spouse and the dead buddy. The aim is to establish a mutually held representation of their situation that integrates past and present. The basic principles include a balanced attention to the spouse's needs for support, the use of physical touching and comforting during the sharing of the traumatic material, and education of the couple about the dysfunctional process.

The critical interaction therapy process adheres to a specific sequence of interventions: 1) Free discussion between the couple. 2) A conflict occurs that provokes a withdrawal of the veteran from the interaction, signaled by an eye shift, pause, or postural shift—the potent nonverbal response noted by Rosenheck and Thomson (1986). 3) The therapist inquires about and elicits the traumatic memory from the veteran. 4) The spouse is asked to physically comfort the veteran by holding his hands and looking into his eyes. 5) The veteran is asked to retell his story to his spouse in detail, allowing him to grieve in her presence. 6) Once this is completed, the therapist points out to the couple how that memory is connected to the repetitive conflict in their relationship. 7) The veteran is asked to check in with the spouse and to comfort her, demonstrating his capacity for solacing. 8) The therapist reviews the entire sequence and identifies the behaviors of each partner. 9) The therapist assigns homework to the spouses by suggesting how they might structure their behaviors when conflicts occur at home, and then (10) rehearses these behaviors in the session.

We have found this sequence to be reliably effective. Three of these elements are particularly important to the success of this approach. First, it is essential for therapists to notice the withdrawal of the veteran, which at times can be quite subtle, and to overcome their own hesitancy about asking him if he is thinking about something else, even though they may feel uncomfortable about interjecting what may seem to be a non sequitur comment, or about distracting the couple from the immediate issue.

Second, the use of physical comforting by the couple is another essential element of the process. We have found that without physically touching the veteran, by holding hands or hugging, the spouse often maintains an emotionally distanced, shut-off stance that the veteran mirrors and then responds to by becoming more vague in his reporting of the trauma. We have been impressed by the lack of physical intimacy and ability to provide physical comfort among these couples, apparently another consequence of years of defensive withdrawal and fear of emotional expression. Nonverbal, physical connection between couples apparently allows rapid transfer of emotional states and provides a concrete demonstration of support to the veteran. The result is often a burst of emotion and grieving from the veteran, who then clings to his spouse who responds less defensively and with more caring.

A third essential element is turning the veteran's attention to his spouse after he has told her about his trauma. Without insuring that there is this balance of support in the relationship, the therapist may enhance the dysfunctional role pattern of disabled veteran/compensating wife. The therapist should spend some time helping the veteran to inquire about how his wife felt while listening to him, helping the wife voice her own pain and needs, and to encourage the veteran to show his care for her now in the session.

Using the critical interaction method, we now present three detailed transcripts of actual sessions with veterans and their wives.

The Child

This is the second family meeting for Tom and Rebecca. They are discussing with the therapist Tom's difficulty in creating relationships with Rebecca's three sons. At family functions, Tom either isolates himself, is irritable, hostile, or explosive. Ultimately, he leaves without explaining to anyone what the problem is. He is perceived by Rebecca's sons as rude, inconsiderate, and irresponsible. Tom and Rebecca have been a couple for 7 years and Rebecca is committed to him. Tom is asking the therapist for help in creating a better relationship with Rebecca's adult children. At this point, Tom looks down, away from the therapist and Rebecca. He looks distracted as Rebecca continues to talk. The therapist takes the nonverbal cue as a signal that Tom is cut off from the present, has moved into a past feeling state that is being triggered by the present emotional process. As the therapist intervenes, the first step of critical interaction therapy unfolds.

Th: Tom, you have left us . . . Where are you?

Tom: I'm in Nam. (Continues to look down, a sad expression on his face.)

Th: Look at Rebecca.

Tom: I can't.

Th: Rebecca, hold Tom's hands and look into his eyes.

Tom: I can't look into her eyes.

Th: Look into her eyes, breathe, you've stopped breathing . . . Bring yourself back.

Tom: (Follows directive and looks at Rebecca.)

Th: Tell Rebecca what you are seeing.

Tom: I can't. (Silence. He looks down again. Rebecca is watching him with an intent expression.)

Th: Rebecca, can you listen to the painful thing Tom is seeing and not leave?

Rebecca: Yes, I can.

Th: Ask Tom what he is seeing.

Rebecca: Tom, what are you seeing?

Tom: A young boy crushed to death. How could I have done it? I didn't know if he was the enemy. How could I have done that? I just slowly backed the jeep up and crushed him.

Th: Tell us more about this. Rebecca can hear you.

Tom: (Crying, he describes the mission they were on and how he made a decision to kill this child not knowing if he was the enemy.) The kid was carrying a bundle. It could have been an explosive! But none of us knew for sure. Later I had to bring the child's body back to his parents. (Tom is hunched over, body stiff as he cries. Rebecca is now crying as well.)

Rebecca: Don't blame yourself. It was war. You did what you had to . . .

Th: Tell him to tell you more, Rebecca.

Rebecca: Tell me more Tom.

Tom: (Describes more of the incident, breathing very fast, sweating, body rigid.) I can't go on. I can't do this. I need to stop.

Th: Rebecca, this is very painful for Tom. He needs you now. Hug him and let him cry with you. Help him go on.

Rebecca: (She pulls Tom to her and hugs him. Tom relaxes slightly as he cries and is held. When he seems to have found relief the therapist continues to explore the underlying emotions.)

Th: Tom, this is important. Important for you to let out and for Rebecca to learn about. How are you feeling?

Tom: I feel so ashamed when this happens. I don't want anyone to know. I just want to be alone.

Th: Why?

Tom: I don't deserve to be alive.

Th: Look at Rebecca. Tell her what you are feeling.

Tom: Ashamed. You have children. You love them. What if somebody killed your children. How could you accept that?

Rebecca: (upset) You had to do what you did.

Th: Rebecca, are you disgusted by this man?

Rebecca: No, he knows that I understand. I have told him he had to do what he did.

Th: Tom, you don't quite believe her, do you? Do you think that if you tell Rebecca these things that she will eventually leave you in disgust?

Tom: How could she love someone like me? I don't deserve to live. I should change places with that child. But if I did that I would be abandoning Rebecca, so I can't be here and I can't be there.

Th: I think I understand that. So you deaden yourself inside in order to escape?

Tom: Yes. (crying) I am dead, Rebecca. That's why I do all of this crazy stuff. To feel.

Th: (Shifting back to the critical interaction.) Stay with this now, Tom because each time that you cut yourself off, Rebecca feels angry at you because she can't help.

Rebecca: Yes, that's it.

Th: Is this how it happens?

Rebecca: Whenever we get together, especially with my family, I eventually see Tom going into himself. He gets quiet and doesn't want to talk.

Th: (to couple) What do you usually do when this happens?

Rebecca: I leave him alone. I know that he wants to be alone.

Th: Tom, how do you feel at these times?

Tom: Lonely.

At this point, they explore how the couple has developed a pattern in which Rebecca allows Tom to move deeper into his internal world, withdrawing from the world, which creates misunderstanding and usually ends in an explosion based on lack of communication. Rebecca states that she has been scared to get him to talk about his memories because when she presses him he shakes, cries, and loses control. Tom then states that he too is frightened of talking about the intrusive memories for fear that he will lose control and hurt someone. The therapist points out that the couple is wise in being cautious, but now they must begin to practice communicating in therapy sessions so that they can continue this outside of the hospital. Tom states that he feels successful in having talked about this memory today without losing control. The therapist congratulates the couple for moving beyond an impasse, which they could not do before, and then focuses on how Tom might begin to relax his body in order to communicate more often.

The Buddy

"Can you believe that twenty years after my buddy's death, that I have never mentioned his name to anyone? I have held his memory inside. I have never cried. I have not betrayed him. I have spoken to him daily. I am angry at him for abandoning me. Often I want to join him and in fact I have tried to kill myself twice and failed. No one can ever take his place. I miss him so much."

After Ben's buddy, Charlie, was killed in Vietnam while standing next to him, Ben remembers feeling unprotected, vulner-

able, rageful, guilty, and finally revengeful. After his buddy died, he characterizes his combat behavior as uncivilized, killing without mercy, without justification, and without feeling. "All I wanted was revenge, I became like an animal programmed to kill."

The veteran's past attempts to share the memories of his buddy with his wife, Naida, had failed because he could only tolerate the pain of talking about the dead when in a drunken state. Naida had no idea how to help and comfort him should he reveal this material, and so never encouraged this exploration on her own. Her helplessness was interpreted by Ben as disinterest, which caused him to withdraw and isolate himself. As a result, Ben developed the idea that his buddy was more valuable and important than his wife.

The session begins with a familiar argument about Ben's drinking. After a few minutes, Ben looks away from Naida and stops talking. The therapist asks what he is thinking about now. Ben says nothing. The therapist asks if it is about Vietnam. Ben nods, and says he is thinking about his buddy.

Th: Ben, I have no doubt that this is extremely difficult for you and it is taking all of your energy just to stay in this room. I want to let you know that this will help. I'd like you to tell Naida about your buddy.

Ben: I can't. Besides I tried once and she walked out on me.

Naida: That's because you were drunk.

Ben: I don't want to burden you.

Naida: (to therapist) You see, there's no way to get through. Everything I've done has made it worse.

Th: Okay. I still want you to tell her about him.

Ben: (Starts telling about Charlie and his death. He stops.)

Th: Naida, hold his hands and ask him to tell you.

Naida: Ben, tell me about him.

Ben: (Recounts the events leading up to Charlie's death. He begins shaking and then crying.)

Th: Keep going. Those are tears you have held back a long time. Naida, can you give Ben some comfort?

Naida: I don't know how.

Th: Hug him.

Naida: (Hugs him while he remains rigid as a statue.)

Ben: (Crying, he completes his story, achieving a great deal of relief. He holds onto his wife very tightly now.)

Th: Ben, can you take Naida's hands in yours, look into her eyes, and ask her what she was feeling as you were talking?

Ben: What were you feeling?

Naida: Angry and sad that you have had to go through that.

Th: Were you feeling repulsed or disgusted?

Naida: He knows I wasn't.

Th: Tell him that.

Naida: Ben, I heard you and I wasn't disgusted.

Th: Ben, that was very difficult for you and I am impressed you were able to tolerate what we just did. You allowed Naida to help you. You didn't isolate or shut her out. That is important. She cannot take Charlie's place but she can love you and comfort you here.

Ben: (nods) Yes.

Th: Now it's important that you check in with Naida and give her back some of what she has given to you. Can you hold her hands again, and find out how she is doing?

Ben is directed to listen to and comfort his wife. The couple is taught in a very

supportive fashion how to listen to each other, maintain eye contact, check out reality, and give physical comfort in a nonreactive manner. By voice intonation and directive, the therapist models new ways of communication for the couple, and provides continuous affirmation of the importance of the work since it is so anxiety provoking. The therapist concludes the interaction by directing Ben to listen to and comfort his wife. Then the couple is directed to use the techniques they have just enacted at home, to hold hands, make eye contact, and hug. Ben is directed to let his wife know when he is having thoughts of Charlie and to share with her more of their experience together.

The pattern created in the therapist's office counters the couple's long-standing pattern of suppressing feelings of loss, hurt, and rejection; of transforming them into anger at self and other; and of isolating themselves from each other through lack of communication.

The Village

Richard and Laurie are present in therapy. Richard has been on an alcoholic binge since discovering that his son is doing crack. Richard blames himself for his son's addiction, but he knows that he is only further complicating the problem by binge drinking. He has wanted to lock his son up in the house, and locate and kill the dealer who sold his son crack. The critical interaction occurs when Richard explains his impulse to kill the dealer, and his wife Laurie tells him to restrain himself.

Richard: I feel like such a failure. It's my fault that my son is doing crack. But now I have to protect him. I want to teach those dealers a lesson.

Laurie: You know you'd just get yourself hurt! (Richard's eyes shift downward and glaze over. His leg is shaking.)

Th: Richard, you are not with us now. What are you seeing?

Richard: I see bodies, strewn everywhere. This is crazy. Body parts, hanging from trees, everywhere, blood, people still alive, blown away.

Th: Where is this, Richard?

Richard: A small village outside Da Nang.

Th: What was your purpose in being there?

Richard: To protect them.

Th: What else do you see?

Richard: An old man, his legs are gone, blown off, pulling himself by his arms towards me, looking at me, crying for help.

Th: What do you do?

Richard: I shot him in the head.

Th: Why?

Richard: To end his suffering. We shot all the survivors. (His whole body is shaking.)

Th: What are you feeling, Richard?

Richard: Nothing.

Th: Richard, I want you to hold onto your wife now. (He does so.) Stay with us, don't cut off. Let it come out now.

Richard: I can't. (Begins crying.)

Th: What else do you see?

Richard: We are throwing bodies into huge holes, covering them with lime. Men, women, children, animals, the whole village, destroyed, innocents. They were innocent. We were there to save them and instead we killed them.

Th: What are you feeling?

Richard: Guilt. I shouldn't have returned home. I've hurt enough people already.

Th: You never would have hurt your son or wife if you had died in Nam.

Richard: That's it. I have failed.

Th: What did you do after that mission?

Richard: We drank in a hotel in Saigon for five days straight.

Th: Is this connected to what happened to your son?

Richard: Yes, I couldn't even protect my own son. I feel so ashamed.

Th: Look at Laurie and tell her that.

Richard: I never should have come back. You and Billy don't deserve this.

Th: Ask her what she is thinking as she hears this.

Richard: (Looks at wife.)

Laurie: I feel sad for you, and sad for us. I need you to help me. This is not Vietnam.

Th: How do you feel about Richard?

Laurie: I love you. (She leans forward and they hug.)

The therapist then points out how Richard's isolation leaves Laurie feeling helpless. She withdraws from him and he feels rejected. This then evokes his shame and rage, which he directs toward her. Communication is stopped and the problems are not solved. The couple is directed to identify those moments when Richard withdraws into a Vietnam memory, to have him relate it to her while they hold hands, and then to comfort each other.

It is likely that the incident with his son reactivates memories of the Vietnam massacre, leading to the alcoholic binge and plans for revenge. In contrast, treatment can allow mourning for the lost people, unlocking the past from the present, and give him more distance to solve the immediate problem. His wife is enabled to help and comfort him, which she can do when he openly shows his suffering; he is then instructed to check in with her and comfort her, thus balancing their roles.

CLINICAL APPLICATIONS

We propose that an interpersonal structure similar to the critical interaction occurs in every traumatized family because the simultaneous need to deny and to acknowledge the horror of the event is likely to lead to its covert symbolization in current family interactions. However, the critical interaction therapy approach may not be applicable to certain types of trauma, such as traumas that did not involve close attachments to other people (for example, a single car accident, rape by a stranger); where the trauma has not been kept secret from some members of the family (when the event occurred to the entire family, such as the house burning down); or when the trauma involved violence between members of the family (family incest or abuse). In these cases, other approaches or modifications of the critical interaction therapy method may be required.

The critical interaction approach, however, does facilitate the processing of combat-related memories of Vietnam veterans with their spouses in an experientially immediate context that provides support and structure to the couple, and that acknowledges both spouses' needs for help. In clinical situations where there is not time to establish a longer-term couples treatment, with preparatory disjoint and then conjoint meetings, or when the veteran is developing too much anticipatory anxiety about talking about his traumas, this approach is indicated. This approach is less useful when the two spouses have decided to separate or divorce, when little underlying concern for each other remains, or when the veteran's abuse of the wife has not been acknowledged and curtailed. The use of nonverbal cues to identify the critical interaction, physical comforting between the couple, and therapist activity help to circumvent impasses or explosive emotional reactions.

Due to its structured design, trainees have been able to learn this method quickly. Couples have responded positively to this work: the veteran feels that it respects his Vietnam experience, while the spouse feels that it empowers her and shows her that he is still human. The unacknowledged assimilation of the Vietnam memories into the family dynamics is brought to light, providing an opportunity for greater mutuality in their representations of the situation. Once such mutuality is established, the family members have a base upon which to build a greater sense of control, a renewed ability to problem solve, and the capacity to mourn the heavy losses they have endured. Only later can therapeutic work focus on the transformation of these representations of the problem into more flexible, less problem-saturated forms.

REFERENCES

Blank, A. (1985). The unconscious flashback to the war in Vietnam veterans: Clinical mystery, legal defense, and community problem (pp. 293–308). In S. Sonnenberg, A. Blank, & J. Talbot (eds.), *The trauma of war: Stress and recovery in Vietnam veterans.* Washington DC: American Psychiatric Press.

Figley, C.R. (1983). Catastrophes: An overview of family reactions (pp. 3–20). In C.R. Figley & H.I. McCubbin (eds.), *Stress and the family. Volume II: Coping with catastrophe.* New York: Brunner/Mazel.

_____. (1986). Traumatic stress: The role of the family and social support system (pp. 39–56). In C.R. Figley (ed.), *Trauma and its wake, Volume II.* New York: Brunner/Mazel.

_____. (1989). *Helping traumatized families.* San Francisco: Jossey-Bass.

_____, & Sprenkle, D.H. (1978). Delayed stress syndrome: Family therapy implications. *Journal of Marriage and Family Counseling 4:* 53–60.

Harkness, L. (1993). Transgenerational transmission of war-related trauma (pp. 635–644). In J.P. Wilson & B. Raphael (eds.), *The international handbook of traumatic stress syndromes.* New York: Plenum Press.

Herndon, A., & Law, J. (1986). Post-traumatic stress and the family: A multimethod approach to counseling (pp. 264–279). In C.R. Figley (ed.), *Trauma and its wake, Volume II.* New York: Brunner/Mazel.

Jurich, A.P. (1983). The Saigon of the family's mind: Family therapy with families of Vietnam veterans. *Journal of Marital and Family Therapy 9:* 355–363.

Kishur, G., & Figley, C.R. (1987). The relationship between psychiatric symptoms of crime victims and their supporters: Evidence of the chiasmal effects of co-victimization. Unpublished manuscript, Purdue University, West Lafayette, Indiana.

Marrs, R. (1985). Why the pain won't stop and what the family can do to help (pp. 85–101). In W. Kelly (ed.), *Post-traumatic stress disorder and the war veteran patient.* New York: Brunner/Mazel.

Matsakis, A. (1988). *Vietnam wives.* Kensington MD: Woodbine House.

McCubbin, H.I., & Patterson, J.M. (1983). Family transitions: Adaptation to stress (pp. 5–25). In H.I. McCubbin & C.R. Figley (eds.), *Stress and the family. Volume I: Coping with normative transitions.* New York: Brunner/Mazel.

Rosenheck, R., & Thomson, J. (1986). "Detoxification" of Vietnam war trauma: A combined family-individual approach. *Family Process 25:* 559–570.

Silver, S., & Iacono, C. (1986). Symptom groups and family patterns of Vietnam veterans with post-traumatic stress disorder (pp. 78–96). In C.R. Figley (ed.), *Trauma and its wake, Volume II.* New York: Brunner/Mazel.

Stanton, M.D., & Figley, C.R. (1978). Treating the Vietnam veteran within the family system (pp. 281–290). In C.R. Figley (ed.), *Stress disorders among Vietnam veterans: Theory, research, and treatment.* New York: Brunner/Mazel.

Williams, C.M., & Williams, T. (1985). Family therapy for Viet Nam veterans (pp. 193–210). In S. Sonnenberg, A. Blank, & J. Talbot (eds.), *The trauma of war: Stress and recovery in Viet Nam Veterans.* Washington DC: American Psychiatric Press.

Manuscript received January 10, 1995; revision submitted July 27, 1995; accepted July 31, 1995.